Evidence for addition of usual residence of deceased is shown on FILM NO. G 95 MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-a)

CERTIFICATE OF DEATH

03877

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Pisgah
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Pisgah
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Meredith Abell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah J. Abell
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): April 28 1873

8. AGE:

Years	Months	Days	If less than one day
71	11	24	____ hrs. ____ min.

9. Birthplace: Pisgah - Charles Co. Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business
FATHER 12. Name: William Abell
FATHER 13. Birthplace: Prince William Co. Va.
MOTHER 14. Maiden name: Mariam B. Speake
MOTHER 15. Birthplace: Charles Co. Md.
16. Informant: Robert Abell
Address: Pisgah, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 23 1945 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Chicamuxen Md.
18. Funeral director: Hunt & Pyon
Address: Waldorf Md.
19. April 22 1945 (Date rec'd by registrar) Mary Southerland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1945, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 2 1945, to Apr 21 1945 and that I last saw him alive on Apr 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage.	
Due to: Cardio-renal-vascular	
Due to: disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George O. Bicknell M.D. (M. D. or other)
Address: Marlboro Md Date signed: Apr 22 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

03878

CERTIFICATE OF DEATH

Reg. Diat. No. 165

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs.

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Baby Girl Dent

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 30, 1945

8. AGE:

Years	Months	Days	If less than one day
0	0	0	18½ hrs. ..... min.

9. Birthplace: Waldorf Charles Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Francis Butler

13. Birthplace: Md

MOTHER

14. Maiden name: Louise ~~Dent~~ Dent

15. Birthplace: Md

16. Informant: Alice Dent

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 2 1945 (month) (day) (year)

Cemetery or crematory: St-Peters

Location: Waldorf

18. Funeral director: Hunter & Ryon

Address: Waldorf-Md

19. May 2 1945 (Date rec'd by registrar) M. L. Mowbray (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on April 30, 1945, to 19..... and that I last saw h...er...alive on April 30, 1945

Immediate cause of death: Prematurity (birth wgt. 2 1/4 lbs.) — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jane L. MacKavanagh, M.D. M. D. or other

Address: La Plata, Md. Date signed: 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03879

CERTIFICATE OF DEATH

Reg. Diat. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: White Plains md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: White Plains Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Columbia J Dyson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Wid

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 30 - 1863

8. AGE:

Years	Months	Days	If less than one day
81	6	3	..... hrs. ..... min.

9. Birthplace: Port Tobacco md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: William H Lucett
13. Birthplace: Chas Co
MOTHER 14. Maiden name: Edith Wilson
15. Birthplace: Chas Co md
16. Informant: William Dyson
Address: White Plains md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-45 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waldorf md
18. Funeral director: Hunt & Ryon
Address: Waldorf md
19. April 2 1945 (Date rec'd by registrar) H. L. Dodson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1945 at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1938 to April 2 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. L. Wahn M.D. M. D. or other
Address: Waldorf Md Date signed 4-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-D)

CERTIFICATE OF DEATH

03880

Reg. Dist. No. 105

FILM No. C-95

1. PLACE OF DEATH: MAY 28 1945

County: Charles

City or town: Indian Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Shift Employment basis

Hospital, institution, or street address where death occurred: U.S. Naval Powder Factory Indian Head, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Indian Head, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 Cogswell Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: World War One

3.(a) FULL NAME: Clyde Foster (Chester, first name)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Lillian Foster

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): October 14, 1898

8. AGE: Years	Months	Days	If less than one day
46 ~~47~~	Oct.	14	....hrs. ....min.

9. Birthplace: Wellston, Ohio (Town, county, and state)

10. Usual occupation: Powder Factory Attendent

11. Industry or business: USNPF

FATHER 12. Name: John Foster

FATHER 13. Birthplace: Wellston, Ohio

MOTHER 14. Maiden name: Margret Phillips

MOTHER 15. Birthplace: Wellston, Ohio

16. Informant: Mrs. Clyde Foster

Address: 123 Cogswell, Indian Head, Md.

17. (Burial, cremation, or removal, which?) Burial Date thereof (month) 4 (day) 21 (year) 45

Cemetery or crematory: Fairview

Location: Mishawaka Ind.

18. Funeral director: Hunt and Ryan

Address: Waldrof, Maryland

19. (Date rec'd by registrar) 4-20 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 45 at 6:12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to April 19 19 45

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Explosion, blast concussion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 4/19/45

Where did injury occur? Indian Head (City or town) Charles (County) Md. (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: Hunt G. Swan M.D. M. D. or other

Address: Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-e)

CERTIFICATE OF DEATH

03881 'S

Reg. Diat. No.

1. PLACE OF DEATH:

County: Charles

City or town: Indian Head,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? began employment began 4 PM

Hospital, institution, or street address where death occurred:
U.S. Naval Powder Factory

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D C County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 Eye St.NW
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GOLDMAN Garris [redacted]

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife: ~~Dora Goldman~~ Dora Garris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26, 1926

8. AGE: Years	Months	Days	If less than one day
18	10	23	hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation: Powder Factory Attendent

11. Industry or business: USNPF

FATHER — 12. Name: Goodman Garris

FATHER — 13. Birthplace: South Carolina,

MOTHER — 14. Maiden name: Roxanna Johnson

MOTHER — 15. Birthplace: South Carolina

16. Informant: Roxanna Garris

Address: 414, I St. N.E. Washington D.C.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 4 (day) 23 (year) 45

Cemetery or crematory: Linton Cemetery

Location: South Carolina

18. Funeral director: Hunt and Ryan 2031

Address: Waldrof, Maryland

19. (Date rec'd by registrar) april 20 19 45 Registrar: M. C. Mudd

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 19 45 at 6:12P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to April 19 19 45

and that I last saw h alive on 19

Immediate cause of death	DURATION
Explosion, Blast concussion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4/19/45

Where did injury occur? Indian Head (City or town) Charles (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury: Blast Concussion Injured at work? Yes

23. SIGNATURE: Frank G. Swan M.D. M. D. or other

Address: Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

03882

Reg. Dist. No. 165

1. PLACE OF DEATH:

County Charles

City or town Indian Head, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Employment began at 1pm

Hospital, institution, or street address where death occurred:

U.S. Naval Powder Factory, Indian Head, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Rural Indian Head, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOHN LORENZO GREENHOW

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife RosaLee Carolyn

6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) August 31, 1913

8. AGE: Years	Months	Days	If less than one day
31	8	6	....hrs. ....min.

9. Birthplace Indian Head, Maryland (Town, county, and state)

10. Usual occupation Powder Factory Attendent

11. Industry or business USNPF

FATHER 12. Name George Greenhow

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Rebecca Watts

MOTHER 15. Birthplace LaPlata, Maryland

16. Informant Mrs. Rosalee Greenhow

Address Indian Head, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21-1945 (month) (day) (year)

Cemetery or crematory St Charles

Location Keymount Md

18. Funeral director Hunt and Ryan

Address Waldrof, Md.

19. Apr 20 1945 M. [illegible] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945, at 6:12P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....1945, to April 19 1945

and that I last saw h....alive on 1945

Immediate cause of death	DURATION
Explosion Blast Concussion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/19/45

Where did injury occur? Indian Head (City or town) Charles (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury Blast Concussion Injured at work? Yes

23. SIGNATURE Frank E. Swan M. D. M. D. or other

Address Indian Head Md Date signed 4/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (147-d)

03883

CERTIFICATE OF DEATH

Reg. Dist. No. 108

1. PLACE OF DEATH

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2

Hospital, institution, or street address where death occurred: Phys. Mem. Hosp

How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: La Plata Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Eleanor Lyles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M.

6.(b) Name of husband or wife: Archie Lyles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-29-1[illegible]

8. AGE:

Years	Months	Days	If less than one day
37	8	3	..... hrs. ..... min.

9. Birthplace: Port Tobacco Charles Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Mathew Hinton

13. Birthplace: La Plata Md

MOTHER

14. Maiden name: Mary Rustin

15. Birthplace: La Plata Md

16. Informant: Archie Lyles

Address: La Plata Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 4-6-45 (month) (day) (year)

Cemetery or crematory: Dorset Hunt

Location: La Plata, Md

18. Funeral director: Hunt & Ryan

Address: Hardoy Md

19. 4-3 19 45 Julia H. Posey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 7 1945, at 8 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-7 1945, to 4-7 1945 and that I last saw her alive on 4-7 1945

Immediate cause of death	DURATION
Pulmonary Embolism	4-7-45
Due to: Pelvic Phlebitis	
Due to: Childbirth	3-30-45
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Adeleen M. D. M. D. or other

Address: La Plata Md Date signed 4-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of usual residence of deceased is shown on FILM No. G 95 MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03884

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James T. Milstead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	White	Married

6.(b) Name of husband or wife: Mary E. Milstead 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): Mch 8 1878

8. AGE:

Years	Months	Days	If less than one day
67	1	7	hrs. min.

9. Birthplace: Chicamuxen Chas Co. Md (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business
FATHER 12. Name: Albert Milstead
13. Birthplace: Charles Co. Md
MOTHER 14. Maiden name: Alcinda Franklin.
15. Birthplace: Charles Co. Md.
16. Informant: Spencer Milstead
Address: Marbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 17 '45. (month) (day) (year)
Cemetery or crematory: Methodist
Location: Chicamuxen Md.
18. Funeral director: Dent & Ryon.
Address: Waldorf Md.
19. April 16 1945 (Date rec'd by registrar) Mary Sutherland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 15 1945, at 7 35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1944, to Apr 15 1945 and that I last saw him alive on Apr 1945

Immediate cause of death	DURATION
Cerebrovascular Cardio-renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bickmell M.D. (M. D. or other)
Address: Marbury Md Date signed Apr 16 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

03885

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Ferdinand Wright.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Ann Wright
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 9 1859

8. AGE:

Years	Months	Days	If less than one day
85	8	1	... hrs. ... min.

9. Birthplace: Nanjemoy Chas Co Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Silas Wright
13. Birthplace: Charles Co Md.

MOTHER
14. Maiden name: Catherine Harbin
15. Birthplace: Chas Co

16. Informant: Jessie C. Wheeler
Address: Indian Head Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Apr 13 1945
(month) (day) (year)
Cemetery or crematory: Baptist
Location: Nanjemoy Md
18. Funeral director: Hunter & Rose
Address: Waldorf Md

19. April 12 19 45 M. L. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 10 1945 at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Apr 10 1945
and that I last saw b[illegible] alive on April 10 1945

Immediate cause of death	DURATION
Myocardiosis	
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: George C. Bicknell M.D.
M. D. or other
Address: Marlboro Md Date signed: April 10 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-D)

03886

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles Co
City or town: Tomoukey Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles-Co
City or town: Tomoukey
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bryans Road P.O., Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELLA YOUNG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	married

6.(b) Name of husband or wife: John C. Young
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace
MOTHER 14. Maiden name
MOTHER 15. Birthplace
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-45 (month) (day) (year)
Cemetery or crematory Metropolitan M.E. Church
Location Pomonkey
18. Funeral director Barnes & Matthews
Address 614-4th St. S.W. Washington D.C.
19. April 16 1945 (Date rec'd by registrar) M.E. Ransome Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 6 1945, to April 15 1945
and that I last saw her alive on April 13 1945

Immediate cause of death	DURATION
Auricular Fibrillation & Chronic Myocarditis	1 mo
Due to: Arterio-Sclerosis	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E. Barnes M.D.
M. D. or other
Address Washington D.C. Date signed 4/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03887

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Malcolm

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Malcolm

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Leo Young

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	17	..... hrs. ..... min.

9. Birthplace: Malcolm, Charles, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: John Young

FATHER — 13. Birthplace: Malcolm, Md.

MOTHER — 14. Maiden name: Henrietta Hawkins

MOTHER — 15. Birthplace: Aquasco, Md.

16. Informant: Henrietta Young (mother)

Address: Malcolm, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 28 1945 (month) (day) (year)

Cemetery or crematory: St Peters

Location: Faeder

16. Funeral director: Undertaker

Address: Faeder

19. April 27 1945 (Date rec'd by registrar) M. L. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 27 1945, to ..... 19.....

and that I last saw h... alive on Apr. 27, 1945

Immediate cause of death	DURATION
Pneumonia — Type unknown	24 hrs.
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Dep. Med. Examiner

23. SIGNATURE: James F. MacKavanagh, M.D.
M. D. or other

Address: La Plata, Md. Date signed: 4-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15